Name of Physician_____

Physician's Address_____
_____

Date_____

PHYSICIAN'S VERIFICATION OF HANDICAPPED STATUS FOR STATE-AIDED ELDERLY/HANDICAPPED HOUSING

_____ _____
Applicant's Name Applicant's Control Number

_____

_____
Applicant's Address

I herby authorize release of the following information: _____
Applicant's Signature

The Housing Authority is required by state regulations to obtain a physician's certification documenting that an applicant has a qualifying physical or mental impairment in order to determine the applicant's eligibility for elderly/handicapped housing. The applicant has authorized above your release of the requested information. We would appreciate your prompt response to the questions on the reverse side of this letter. If you have questions, please contact our office. Thank you for your anticipated cooperation.

Sincerely,

_____
Executive Director or Tenant Selection Coordinator

EQUAL HOUSING OPPORTUNITY

BE COMPLETED BY PHYSICIAN

1. The applicant must have a physical or mental impairment which substantially impedes his or her ability to live independently?

Comment:_____ _____

_____

2. The applicant must have an impairment other than a history of alcohol or substance abuse.

Comment: _____

_____

3. What is the anticipated duration of the Applicant's impairment? (If indefinite so specify, and estimate the approximate duration to the best of your ability).

_____

4. Would suitable housing conditions improve the applicant's ability to live independently

and, if so, what sort? Be specific. _____

_____

5. Other comment: _____

_____

_____

PHYSICIAN'S CERTIFICATION

I certify that the information provided above represents my professional judgment and is true and correct to the best of my knowledge and belief.

_____ Date:_____

Signature MD

Name:_____ Address:_____

Telephone # (___)_____.

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